

Housing First: Harm Reduction at the Intersection of Homelessness and Substance Use

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Abstract

Despite a considerable overlap between people experiencing homelessness and people living with substance use disorder, there is a marked lack of integration between Hawai'i's systems of care for these populations. This gap in the current system of care often creates barriers to services for those living at the nexus of homelessness and substance use. This article describes Hawai'i's current homelessness and substance use systems of care, paying particular attention to the intersection between these two systems. With Hawai'i consistently ranking among the highest per capita rates of homelessness in the United States, this article argues that the intersection of homelessness and substance use is a pivotal site of intervention for addressing significant social problems. This article positions the Housing First paradigm as a critical model for bridging gaps and eliminating barriers in service provision through systems integration at the program level. Greater fidelity to the broader harm reduction principles underlying this model will effectively organize and equip programs to successfully address the needs of people experiencing homelessness and struggling with substance use.

Keywords

homelessness, substance use, housing first, harm reduction

Abbreviations and Acronyms

ADAD = Alcohol and Drug Abuse Division of the Hawai'i Department of Health
AOD = alcohol and other drugs
ASAM = American Society of Addiction Medicine
BJA = Bureau of Justice Assistance
CARES = Coordinated Access Resource Entry System
CES = Coordinated Entry System
CIS = community integration services
DOH = Department of Health
HF = Housing First
HMIS = Homeless Management Information System
HPO = Homeless Programs Office
HUD = Housing and Urban Development
LEAD = Law Enforcement Assisted Diversion
MAP = managed alcohol program
PEH = people experiencing homelessness
SEM = Social-Ecological Model
SoC = system of care
SUD = substance use disorder
TLP = therapeutic living program
USICH = United States Interagency Council on Homelessness
VISPDAT = Vulnerability Index–Service Prioritization Decision Assistance Tool

Background and Introduction

For people experiencing homelessness (PEH) and struggling with harmful substance use or substance use disorder (SUD), a lack of integration between Hawai'i's homelessness and substance use systems of care (SoCs) presents consistent barriers to effective service provision. For example, participation in residential treatment programs may disqualify a person seeking housing assistance from accessing permanent housing support; or a housing program may exit a housed individual for recurrent substance use. As Hawai'i continues to have one of the highest per capita rates of homelessness in the nation, the intersection of homelessness and substance use is an increasingly pivotal site of intervention for addressing significant social problems.

Data from Hawai'i's 2020 Point in Time Count shows that on a single night in 2020, there were approximately 4448 individuals experiencing homelessness on O'ahu and 2010 individuals on the neighbor islands.¹ Of those counted, 683 (18%) indicated harmful substance use on O'ahu and 460 (28%) on the neighbor islands. Compared to neighboring islands, substance use was slightly higher among both sheltered (350, 24%) and unsheltered (333, 27%) populations on O'ahu.² Approximately 1 in 7 PEH on O'ahu reported problematic substance use as a cause of homelessness, making it the third most common self-reported cause of homelessness (14% of respondents), behind an inability to pay rent and the loss of employment. These findings are consistent with other populations experiencing homelessness in comparable municipalities in the continental US.^{2,3}

Current data and the historical persistence of homelessness in Hawai'i suggest that ongoing structural forces significantly contribute to homelessness and the trauma experienced when living unsheltered.⁴⁻⁶ For example, economic causes of homelessness outweigh alcohol and drug use 3 to 1 (44% versus 14%).² In understanding these structural roots of homelessness, this article argues for integrated programmatic solutions that work across multiple levels to meet individuals with compassion and support rather than moralizing or stigmatizing harmful behavior. Hawai'i can fortify existing interventions, such as permanent supportive housing and intensive case management, to better meet the needs of PEH.

Homelessness and substance use are embedded within a complex network of structural forces (eg, economic, political, and social conditions). While treatment of SUD still focuses on the individual level, appropriate care requires interventions that consider personal health within the context of larger structural forces that provide leverage points for effecting change. Trauma and structural violence further exacerbate homelessness and substance use. In recent years, Hawai‘i’s laws have increasingly criminalized those visibly experiencing homelessness. Where structural violence limits individual choices, harm reduction offers an integrated public health approach to structural change that affords greater agency to individuals living with trauma through holistic, person-centered methods.

Grounded in social justice and human rights, harm reduction is a set of practical strategies and ideas designed to reduce the negative consequences associated with harmful substance use.⁷ Close adherence to harm reduction principles will effectively organize and equip programs to successfully address homelessness and substance use on multiple levels and across complex systems. Existing programs can increase fidelity to these principles by addressing multiple levels of trauma, integrating the homelessness and substance use SoCs, and helping clients maintain eligibility for supportive services throughout their journey of care. Housing First (HF) is an evidence-based intervention exemplary of harm reduction principles that considers individual, community, and structural levels in its design.

This article positions the HF paradigm as the most promising solution for addressing homelessness and substance use. HF is an integrated approach to homelessness that aims to “quickly and successfully connect individuals and families experiencing homelessness to permanent housing without preconditions and barriers to entry, such as sobriety, treatment, or service provision.”⁸ The model is built around the belief that PEH have the right to housing as a foundation for improving their quality of life regardless of their status of harmful substance use. While remaining recovery-oriented, HF better retains clients in care and provides more effective treatment because it does not condition housing or support on abstinence or penalize recurrent substance use. In this way, HF accommodates the fluctuating position of clients in their process of change. The following sections illustrate that harm reduction interventions such as HF, diversion, and managed alcohol programs (MAPs) have been successful thus far, demonstrating the benefit of implementing full-scale programs and expanding resources to provide housing and wraparound support for PEH.

Hawai‘i’s Current System of Care

Hawai‘i’s current SoCs for homelessness and substance use encompass an evolving network of resources and referrals that intersect the behavioral health system. The Coordinated Entry System (CES) for shelter and housing and the Hawai‘i Coordinated Access Resource Entry System (CARES) for substance

use represent the fundamental components of these systems. CES facilitates the coordination of housing assistance within the housing SoC by quickly and effectively linking eligible individuals and families to resources and services that best meet their needs.⁹ Partners in Care (on O‘ahu) and Bridging the Gap (for neighbor islands) represent Hawai‘i’s homeless services provider coalition.¹⁰ CARES is a free, 24-hour referral program for substance use and mental health services. Prior to the launch of these programs, access to housing assistance or state-funded substance use treatment was fragmented into distinct entry processes for each program. CES and CARES provide a solution by offering a single-entry point for each SoC.

PEH who struggle with harmful substance use may access housing resources through formal residential or outpatient treatment. “Clean and sober” homes can be accessed through the Department of Health’s (DOH) Alcohol and Drug Abuse Division (ADAD) Clean and Sober Homes Registry.¹¹ Emergency and transitional shelters can be accessed directly. The Office of the Governor’s Coordinator on Homelessness produces a vacancy list for these sites that is updated daily with available bed spaces and eligibility criteria for access.¹² Sites include traditional homeless shelters and specialized housing, such as DOH’s Adult Mental Health Division-funded housing for people struggling with mental health challenges.¹³ In addition to residential treatment facilities that provide housing and SUD treatment, ADAD funds 9 therapeutic living programs (TLPs) statewide. TLPs are long-term supervised living arrangements that provide mental health and substance use services to individuals or families transitioning to independent living.¹⁴ TLPs can be utilized across the SUD SoC to provide PEH with stable shelter as they access treatment and other services.

For individuals seeking access to substance use treatment services while unsheltered, the main access point is the CARES line. Access to CARES is via telephone, requiring that PEH have their own phone to call in and receive calls with updates once a program space is available unless a case manager or outreach worker is the point of contact and knows where to find them. ADAD has addressed this gap by funding outreach and transportation as part of its treatment contracts.¹⁵ Other barriers include a lack of accommodations for those who continue to use substances or use certain pharmacotherapies, which would not be a barrier to housing placement under the HF model.

PEH who struggle with substance use and are not ready for treatment can access housing through CES. PEH seeking housing services are assessed using the Vulnerability Index–Service Prioritization Decision Assistance Tool (VISPDAT), which assigns an acuity number to determine the eligibility and prioritization of an individual for available resources. Once a person receives a VISPDAT score and consents to enrollment in the Homeless Management Information System (HMIS) database, they are placed on the “By Name List,” which CES utilizes to match people with available housing resources. There may be

upwards of 3000 individuals on the list at any given time. On average, CES facilitates housing for 50 individuals per month.⁹ Paradoxically, participation in residential treatment for 90 days or more constitutes a break in an episode of homelessness, which may cause a PEH to lose their chronic homelessness status and fall down the list for prioritization of housing resources.

Services for PEH who live with SUD focus on facilitating traditional treatment modalities, including outpatient, residential, therapeutic, and supportive living, intensive outpatient, social detox centers, and methadone maintenance. **Table 1** describes the size of admissions and fund expenditures by type of treatment in Hawai'i. The numbers are aggregated based on a report by

Kim and Zhang¹⁶ from 2015 to 2017. **Figure 1** visualizes the percentages of the admissions and funds in the table by year. Outpatient programs were the highest expenditure of funding sources, costing \$7-8 million dollars or 44% of all funds. By contrast, social detox programs and treatments using methadone are relatively underutilized, with no more than 500 patients admitted per year. This underutilization creates a noticeable bottleneck in the treatment system because detox or medication management for SUD is required before admissions to residential treatment programs, which do not currently have the funding or capacity to handle acute medical symptoms of chemical dependence.

	Outpatient	Residential	Therapeutic & Supportive Living	Intensive Outpatient	Social Detox	Methadone
No. of admissions per year (rounded to 50)	2,500-2,850	500-550	150-200	950-1,000	450-500	1-50
Admissions by modality per year (%)	55-56%	9-11%	3-4%	19-21%	8-10%	0.7-1%
Federal and state funds expended by modality per year (%)	43-44%	30-33%	7-8%	9-11%	2-3%	3%
\$ spent (millions, rounded)	\$7-8	\$5-6	\$1	\$1-2	\$0.4-0.5	\$0.5

^a Adapted from Kim & Zhang, 2018¹⁷

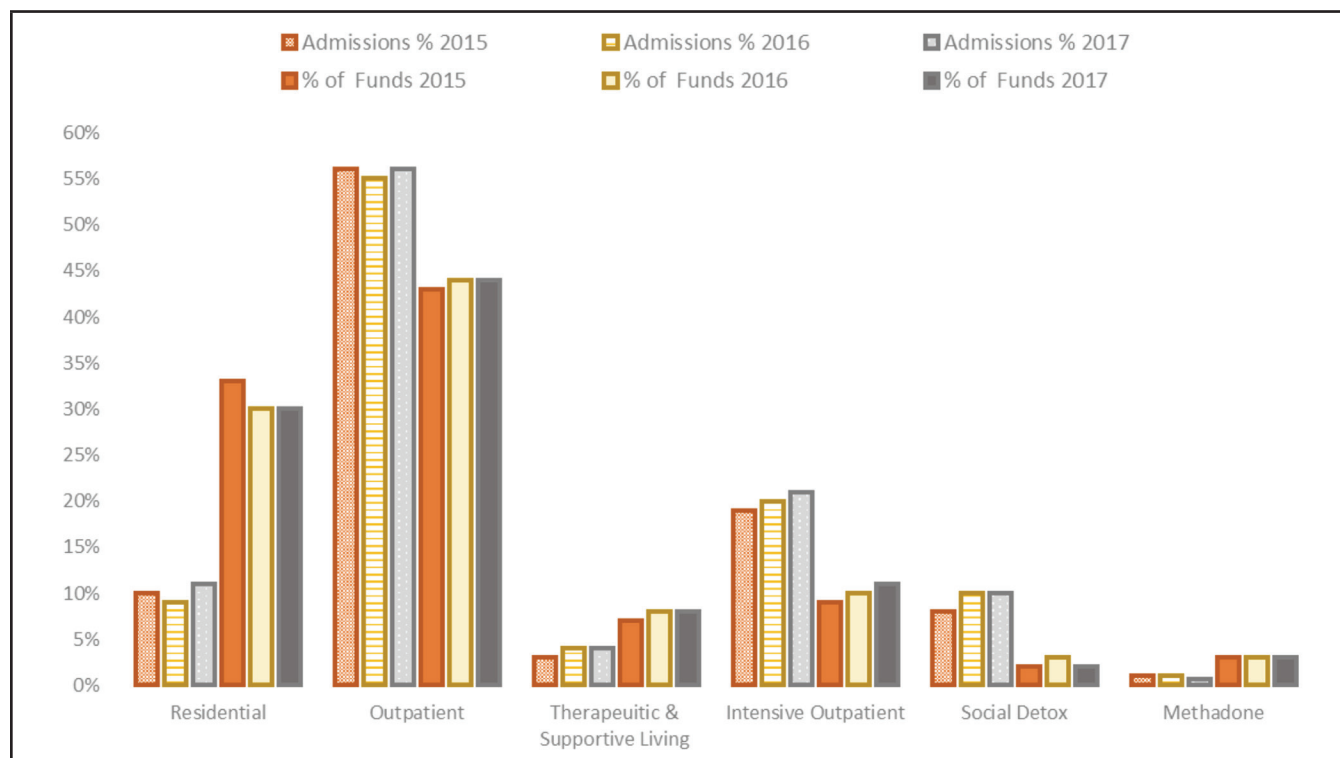


Figure 1. Percentages of Admissions and Funds Expenditure by Type of Treatment (2015 - 2017)^a

^a Adapted from Kim & Zhang, 2018¹⁷

Social detox programs, with an average cost of a little less than a half million dollars per year in Hawai‘i, are also relatively inexpensive. Residential treatment programs are only 9-11% of all admissions but with expenditures roughly on par with outpatient programs costing about \$11 000 per patient per year, providing shelter for only 30-90 days at a time for PEH. In 2020, Hawai‘i spent \$3 million on year-round shelter through HF programs for 351 individuals, costing about \$8500 per person each year.¹⁷ Continued reliance on a historically static model of abstinence-based residential programs presents substantial obstacles for PEH who seek treatment.

Few homeless services include substance use treatment, and few SUD providers offer specific homeless services, although most services lay somewhere in between.¹⁵ PEH who complete residential substance use treatment have limited resources for housing after clinical discharge. Substance use treatment programs have resources to assist with housing placement through clean and sober homes; however, these are difficult for PEH to access as they typically require a security deposit and the first month’s rent.¹¹ Emergency and transitional shelters are accessible individually, but few provide certified substance abuse counselors on-site. Centralization of shelter and specialty housing vacancies at CARES would facilitate better integration of the housing and substance use SoCs.

Interventions and Recommendations

The pervasiveness of homelessness in Hawai‘i is a multilayered issue requiring an integrated, multidimensional approach at many levels and across various social systems. Hawai‘i can look to HF and the innovative implementation of harm reduction principles in programs like Seattle’s Law Enforcement Assisted Diversion (LEAD)¹⁸ and 1811 Eastlake¹⁹ for ways to integrate the homelessness and substance use SoCs in the state. The continuing problem of SUD among PEH requires closer fidelity to the harm reduction principles underlying the ideal model of HF. Hawai‘i can build upon its existing HF programs and make major strides towards resolving homelessness for this subpopulation by: (1) scaling up available HF vouchers to meet the needs of all those who qualify; (2) integrating the entry systems (CES and CARES); (3) utilizing innovative harm reduction-based approaches for those actively engaged in substance use; and (4) relying upon larger, interdisciplinary teams of support for clients, as demonstrated by the intensive case management of LEAD participants, which follows clients into housing and works with HF programs to ensure housing success.

Given the myriad of challenges in finding shelters for those struggling with SUD, state and local policymakers have increasingly focused on funding HF.²⁰ In Hawai‘i, HF was initially launched in 2014 through Hawai‘i’s Pathways Project,²¹ funded by the Substance Abuse and Mental Health Services Administration through ADAD. Hawai‘i’s Pathways Project was modeled after the original Pathways to Housing project, which housed 99

individuals with substance use and mental health challenges. The evaluation of the original project found an 88% housing retention rate and an estimated healthcare cost savings of \$6197 per client per month. Subsequent HF programs were funded statewide by the Hawai‘i Department of Human Services, Homeless Programs Office (HPO).²⁰ The City and County of Honolulu also funds HF permanent supportive housing. A 2019 evaluation of the first increment of the program found that only 8% of participants fell back into homelessness after 5 years.²²

Studies that have examined the effectiveness of HF programs have illustrated its success as an integrated intervention. When implemented with wraparound support services and interdisciplinary care teams, 88% of HF tenants remained housed after 5 years.²³ PEH who use substances report preferring harm reduction services that include shelter and identified that compassion and non-judgment of staff were components of effective treatment.²⁴ Given the success of HF nationally and in Hawai‘i, the model has become the preferred method for working with PEH who also use substances and is required for those programs funded by HPO and the City and County of Honolulu.^{25,26}

Founded in King County, Washington, as a response to the disproportionate imprisonment of minority populations for personal drug use, LEAD provides a solid example of a non-punitive approach to SUD treatment. Hawai‘i recently implemented the model in Honolulu, where 98% of participants reported homelessness within 3 years prior to enrollment. The 2018 Honolulu pilot found 78% of referred clients reported methamphetamine use, while 36% reported alcohol and opioid use. There was 23% reduction in methamphetamine used by the second year of the pilot. The Honolulu LEAD pilot worked to provide the necessary SUD wraparound support and service navigation alongside HF and homeless service providers, seeing clients spend 47% fewer days sleeping on the street. Someone using injection drugs who is not ready for SUD treatment can be connected to the syringe exchange program for safer use supplies or hepatitis C testing and treatment. A person who does not want to stay in a shelter can work with a LEAD case manager in the field to apply for housing resources through CES. Honolulu’s LEAD pilot program shows that a harm reduction approach works in Hawai‘i, where methamphetamine use is a major issue and for which there are generally fewer options for medication-assisted treatment or other non-abstinence-based modalities. LEAD meets individuals at their level of readiness to engage for both housing and SUD treatment, scaffolding steady change that can be sustained over time.²⁷

MAPs are integrated harm reduction interventions for individuals living with alcohol dependence, chronic poverty, and homelessness that focus on reducing harms through the provision of safer spaces and supply of alcohol. MAPs utilize an HF framework to provide accommodation, health, and social support and include the administration of beverage alcohol to

stabilize drinking patterns.²⁸ Seattle's 1811 Eastlake supportive housing program models an HF framework built for people living with alcohol use disorder. The facility includes a clinic and on-site SUD therapists to offer mediation to clients who have difficulty managing anger. Despite only setting out with the goal to provide housing services to underserved individuals, the program reported a 35% decrease in heavy drinking among participants during the first 2 years.¹⁹ The 1811 Eastlake facility saved over \$4 million in foregone costs associated with the provision of public support and health services for PEH in its first year.¹⁹ As with other HF interventions, replicating MAPs in supportive housing environments like 1811 Eastlake in Hawai'i would foreseeably result in reduced costs to the health care and criminal justice systems. This low-threshold approach will reach many of those persons experiencing chronic homelessness who have been rejected by abstinence-based service programs and likely result in improvements in life circumstances and drinking behaviors. Hawai'i's SoCs will be able to more effectively respond to the ongoing behavioral health needs of those who have experienced chronic homelessness and a lack of success in abstinence-based programs.²⁹ Maintaining fidelity to the HF model and harm reduction principles is a cost-effective way to see a measurable reduction in harmful substance use.

Conclusion

With one-fifth of PEH on O'ahu also reporting harmful substance use, integration between the homeless and substance use SoCs will be an important part of any serious effort to solve homelessness and support clients in maintaining stability once housed. Increased coordination between the homelessness and substance use SoCs through CES and CARES can ensure that clients are able to access programs that will address their most pressing concerns. For clients who will require permanent housing support after leaving a residential program, it requires attention to contradictions within the 2 systems; for example, clients who have completed 90 days or longer in a residential program will lose their chronically homeless status and thus be ineligible for many HF programs. While this problem must be addressed on a larger systemic level, individual programs can ensure client retention and success by weaving harm reduction-based treatment into their permanent housing programs. Building on the example of the MAP at 1811 East Lake, Hawai'i's HF programs can work with clients to maintain housing while mitigating the negative consequences of harmful substance use. HF and the harm reduction approach to public health more broadly offer the most promising paradigm from which to treat PEH who struggle with SUD. By addressing substance use among PEH compassionately and with the non-punitive approach of harm reduction, housing and treatment programs in Hawai'i can ameliorate a persistent structural problem in the state and set an example for other jurisdictions in the nation.

Conflict of Interest

None of the authors identify a conflict of interest.

Notice of Duplicate Publication

This article is based on the draft version of a chapter from the Hawai'i State Department of Health Alcohol and Drug Abuse Division (ADAD) State Plan, and all or a majority of the contents within will be subsequently also reproduced in the corresponding chapter of the final version of the ADAD State Plan (<https://health.hawaii.gov/substance-abuse/state-plan/>). While the ADAD State Plan may later be modified as a living document following its release, the material and content found in this article represents a snapshot of the highlights of the ADAD State Plan at the time of the article's publication.

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